Hamilton Chiropractic Health Center

 **Pediatric Chiropractic Intake Form** Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ Male Female

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present Complaint:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did this begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was there an accident or injury involved? Y N Has your child had any past treatment for this complaint? Y N Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Questions/Prenatal History:**

Any complications during pregnancy? Y N Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications taken during pregnancy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cigarettes or alcohol during pregnancy Y N Birth Intervention: Forceps Vacuum C- Section

Complications during delivery? Y N Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genetic disorders or disabilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times has your child been prescribed antibiotics in the past 6 months? \_\_\_\_\_\_\_ Total during lifetime:\_\_\_\_\_\_\_ Has your child received vaccinations? Y N

**Feeding History: Childhood Diseases:**

 Breast Fed; How long: \_\_\_\_\_\_\_\_\_\_ Chicken Pox; Age \_\_\_\_\_\_\_\_\_

 Formula Fed; How long: \_\_\_\_\_\_\_\_\_\_ Rubella; Age \_\_\_\_\_\_\_\_\_\_\_\_\_
Introduced to: Mumps; Age \_\_\_\_\_\_\_\_\_\_\_\_\_

 Solids at \_\_\_\_\_\_\_ Months Whooping Cough; Age \_\_\_\_\_\_\_\_\_\_\_\_\_

 Cows milk at \_\_\_\_\_\_\_\_ Months Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_

Food Allergies or Intolerances: Y N

List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History:**

During the following times your child’s spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

 \_\_\_\_\_\_ Respond to Sound \_\_\_\_\_\_ Cross Crawl \_\_\_\_\_\_Respond to Visual Stimuli

 \_\_\_\_\_\_ Hold Head Up Alone \_\_\_\_\_\_ Stand Alone \_\_\_\_\_\_ Walk Alone \_\_\_\_\_\_ Sit Up Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e.: a bed, changing table, down stairs, etc.). Was this the case with your child? Y N

**Activities:** Is/has your child been involved in any high impact or contact type of sports (i.e.: soccer, football, gymnastics, baseball, cheerleading, dance, martial arts, etc.) Y N

Has your child ever been involved in a car accident? Y N Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other traumas not described above? Y N Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prior surgeries? Y N Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if your child has had any of the following:

 Headaches Postural Imbalances Growing Pains Scoliosis

 Asthma Torticollis Ear Infections Seizures

 Tonsillitis Sleep Problems Digestive Problems Bedwetting

 Autism ADD/ADHD Frequent Fever Colic

 Learning Difficulties Acid Reflux Hip Dysplasia Allergies

**DIET:** How would you rate your child’s diet? Well Balanced Average High sugar/processed foods

**SLEEP:** Number of hours your child sleeps: hours per night \_\_\_\_\_\_\_\_\_\_\_\_\_\_hours per day/naps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sleep Quality: Good Fair Poor

**Authorization to Treat a Minor**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigned parent/guardian having legal custody/guardianship of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, do hereby authorize, request and direct Hamilton Chiropractic Health Center, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and whomever they might designate as an assistant to perform in judgment any examination and chiropractic diagnosis or designate as an assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature: Parent/Legal Guardian